**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

**Respondent Name**
BANKERS STANDARD INS CO

**Carrier's Austin Representative Box**
Box Number 15

**MFDR Tracking Number**
M4-05-8911-01

**MFDR Date Received**
MAY 24, 2005

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary dated December 17, 2012:** "…reimbursement should be in an amount which is the applicable Medicare reimbursement rate at the time of the date of service multiplied by 213.3% to 290% depending on the complexity of the procedure performed." "Further, or in the alternative, because the DWC considers the applicable requirements in Labor Code section 413.011 (d) for determining a fair and reasonable reimbursement when it issues its fee guidelines, the amount in the 2008 Outpatient Hospital Facility Fee Guideline, with some adjustment, is fair and reasonable in this case…the reimbursement rate for hospital outpatient services should be higher than ASC reimbursement; therefore, the Outpatient Medicare reimbursement should use the same factors of 213.3% to 290% plus 31% unless and until the 200% PAF produces a higher reimbursement (as in later years). Therefore, it is appropriate to use this formula in determining a fair and reasonable reimbursement in this case. The amount of reimbursement is $930.48 (ASC Grouper Rate x 213% plus 31%)."

**Amount in Dispute:** Originally listed $10,490.05, per December 17, 2012 position summary $457.03

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "There is currently no fee schedule for outpatient surgery. The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code."

**Response Submitted by:** ESIS

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 28, 2004 | Outpatient Hospital Services | $457.03 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M-Reduced to fair and reasonable.

**Findings**

1. This dispute relates to outpatient hospital services with reimbursement subject to former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "reimbursement should be in an amount which is the applicable Medicare reimbursement rate at the time of the date of service multiplied by 213.3% to 290% depending on the complexity of the procedure performed."
   - The requestor did not submit documentation to support that 213.3% to 290% of the Medicare allowable would yield a fair and reasonable reimbursement.
   - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
   - In the alternative, the requestor states "because the DWC considers the applicable requirements in Labor Code section 413.011 (d) for determining a fair and reasonable reimbursement when it issues its fee guidelines, the amount in the 2008 Outpatient Hospital Facility Fee Guideline, with some adjustment, is fair and reasonable in this case…the reimbursement rate for hospital outpatient services should be higher than ASC reimbursement; therefore, the Outpatient Medicare reimbursement should use the same factors of 213.3% to 290% plus 31% unless and until the 200% PAF produces a higher reimbursement (as in later years). Therefore, it is appropriate to use this formula in determining a fair and reasonable reimbursement in this case. The amount of reimbursement is $930.48 (ASC Grouper Rate x 213% plus 31%)."
   - The 2008 Outpatient Hospital Facility Fee Guideline rates are not applicable to the disputed dates of service.
   - The requestor submitted a copy of the 28 Texas Administrative Code §134.402 preamble to support their position. 28 Texas Administrative Code §134.402 is not applicable to the disputed services.
   - In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | 2/22/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.